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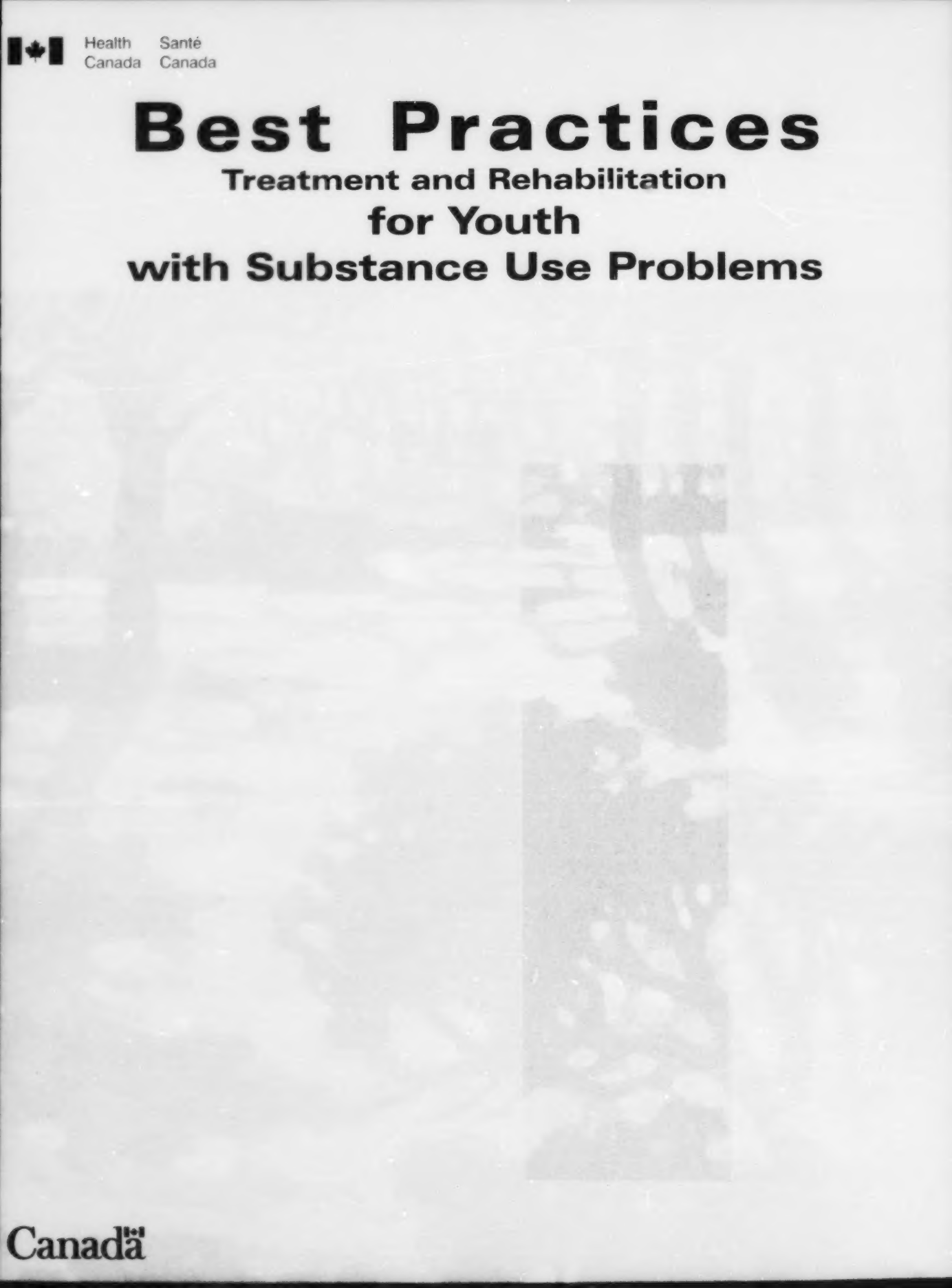
Best Practices

Treatment and Rehabilitation for Youth with Substance Use Problems



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Best Practices
Treatment and Rehabilitation for Youth with Substance Use Problems

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Health Canada

canada's drug strategy

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Summary of Report

This report identifies elements of best practice in the treatment and rehabilitation of youth with substance use problems. Best practices are identified and described in the areas of client outreach, contact and engagement, retention of clients in treatment, overall treatment values/philosophy, specific approaches and methods, relapse prevention, structure of treatment and integration of relevant support services. Recommendations for best practices are based on the results of interviews with 33 key experts and a review of current literature related to these topic areas. The report also addresses barriers to treatment affecting the youth population.

In order to provide a context for examining treatment barriers and effective approaches for youth, the report summarizes general patterns of youth substance use in Canada and provides an overview of factors associated with substance use. Characteristics of specialized population groups, such as street-involved youth, Aboriginal youth or youth involved in the juvenile justice system, are also described.

Personal, family, community (peer) and structural (program)-related barriers are discussed in relation to youth as a whole and in relation to these specialized population groups. Most key experts identified program-related and structural barriers (the overall lack of programs, geographical inaccessibility of services, lack of outreach and lengthy waiting lists) as the most significant barriers affecting access to treatment by youth.

A range of specific barriers to treatment are described, as applying to the specialized groups. For example, according to the key experts, youth with concurrent substance use and mental health/psychiatric disorders are more affected by problems related to coordination and delivery of services while cultural and family beliefs and practices present barriers for ethno-cultural youth.

Key experts identified best practices in the area of treatment contact and engagement in relation to the physical location of treatment, overall program approach and philosophy, outreach and program content and structure. An emphasis on the physical presence of program staff at locations where youth congregate and provision of direct support and training to staff working with youth-serving agencies (particularly schools) are considered critical elements of an outreach strategy.

A realistic view of relapse, a focus on harm reduction, a client-centred, flexible approach to treatment and involvement of the family are essential approaches to retain youth in treatment. A broad psycho-social approach with a focus on skill building, culturally appropriate activities (where applicable) and a recreational component are seen as optimal components of youth treatment.

The report also identifies best practices for addressing physical health, mental health and interpersonal issues as well as relapse management and prevention. Some of the best practices identified are a comprehensive physical health assessment, a holistic response to health issues, nutritional education, healthy lifestyle modelling, practical and creative skill-building approaches, direct parent involvement, a "learning" approach to relapse and an emphasis on group work and supportive peer interactions.

Specific staff characteristics such as staff showing respect and trust, a non-hierarchical approach, acceptance and understanding of relapse, and the ability to model healthy lifestyles are also identified as best practice.

There is consensus among key experts, supported by the literature, that youth treatment should be separated from adult treatment and provide access to a system of care, with the type and duration of treatment matched specifically to client needs. There is also general consensus on the need to provide easy accessibility to adjunctive services coordinated in a variety of ways.

The report also addresses the issue of the measurement of treatment outcomes and effectiveness. Both the literature and key experts suggest that treatment "success" should be measured in a multi-dimensional way using a range of "quality of life" measures, client assessment, as well as reduction in substance use.

This report is organized into two main sections. Section I provides an introduction and background to the project, including project definitions, parameters and limitations. Section II provides the results of the project, including a summary of key expert opinion and outcomes of the literature review. Each sub-section is organized by topic area (e.g. Barriers to Treatment). Both key expert opinion and summaries of the literature (where available) are presented within each of the topic areas.

Section I: Project Background and Description

1. Introduction and Organization of This Report

1.1 Introduction and Background

This project on best practices related to youth treatment was initiated by Health Canada as part of a research agenda developed by the Federal/Provincial/Territorial Committee on Alcohol and Other Drug Issues.

The project was carried out under the direction of an advisory committee: the Working Group on Accountability and Evaluation Framework and Research Agenda of the Federal/Provincial/Territorial Committee on Alcohol and Drug Issues. The mandate of the working group is to develop recommendations for an accountability and evaluation framework for the Alcohol and Drug Treatment and Rehabilitation (ADTR) Program and stimulate the development of innovative substance abuse treatment and rehabilitation programs by identifying best practices, evaluating model treatment and rehabilitation programs, conducting innovative research on emerging issues, and disseminating leading-edge information across the country.

This project has been undertaken simultaneously with another project on best practices for the treatment and rehabilitation of women with substance use problems. Both projects build on initial work undertaken by Health Canada to address best practices in treatment and rehabilitation published as: *Best Practices – Substance Abuse Treatment and Rehabilitation* (Health Canada, 1999a).

1.2 Organization of This Document

This report is organized into two main sections. Section I provides an introduction and background to the project, including study definitions, parameters and limitations. Section II provides the results of the project, including results of both key expert interviews and outcomes of the literature review. Each sub-section is organized by topic area (e.g. Barriers to Treatment). Both key expert opinion and summaries of the available literature are presented within each of the topic areas.

2. Project Objectives and Questions

The overall goal of this project is to:

- Make available across Canada current information on best practices in the treatment and rehabilitation of youth with substance use problems.

The objective of the project is to:

- Define evidence-based "best practices," key components and supports in providing treatment and rehabilitation programs for youth.

Specifically, the project addresses the following questions:

- What are the barriers which affect youth access to or use of treatment?
- What are the best practices leading to the most successful outcomes in the following broad areas related to treatment?
  - client outreach, contact and engagement;
  - retention of clients in treatment;
  - overall treatment values and philosophy;
  - specific treatment approaches (physical, personal and interpersonal issues);
  - relapse prevention;
  - structure of treatment (duration, intensity, organization);
  - integration of relevant support services.
- What is the most relevant, realistic and effective way of defining treatment "success" for youth?
- What are the elements of a model treatment program for youth?

3. Sources of Information

The project used two primary sources of information to identify best practices related to youth treatment, which are described in detail below. These were:

- comprehensive interviews with key experts involved in or relating to youth treatment;
- a focussed review of recent literature describing the elements of treatment most likely to result in positive outcomes.

3.1 Key Expert Interviews

3.1.1 Identification and Characteristics of Key Experts

An initial listing of key experts was compiled from recommendations made by the project's federal/provincial/territorial working group. Key experts were recommended on the basis of their familiarity with a broad range of youth treatment approaches and expertise in identifying optimal elements of treatment. Key experts comprised:

- clinicians working directly with youth in treatment;
- administrators and related staff delivering youth treatment;
- provincial/federal/territorial government policy and program managers.

Table 1: Background of Key Experts

Key Expert Role	Number
Treatment provider (direct)	5
Treatment program director/Counselling coordinator	23
Treatment or policy consultant	5
Total number of key experts	**33**

Table 2: Geographical Distribution of Key Experts

Province/Territory	Total # of Key Experts by Province/Territory	Province/Territory	Total # of Key Experts by Province/Territory
British Columbia	8	Quebec	2
Alberta	2	New Brunswick	2
Saskatchewan	3	Nova Scotia	1
Manitoba	4	Newfoundland	3
Ontario	7	NorthwestTerritories	1
Total number of key experts			**33**

Thirty-three key experts participated in the survey of best practice. In several cases comments and recommendations were amalgamated, resulting in a final grouping of 28 "responses." Most provinces and territories (with the exception of Prince Edward Island and Yukon[1]) were represented.

1 Contact could not be made with respondents in all areas.

There was a balance of types of treatment represented by the key expert groups. Although the mandate of the programs is often broad (residential programs typically offer aftercare or outreach), all basic types of treatment were represented.

Table 3: Types of Programs Represented by Key Experts

Type of Program Represented	Number of Key Experts
Primarily detox programs	2
Multi-level programs (prevention, out-patient and residential)	9
Primarily residential	8
Primarily out-patient	7
Intensive day program	2
Program and policy development	5
Total number of key experts	**33**

3.1.2 Key Experts Interviews: Methodology

Key experts were interviewed by telephone using a detailed interview format consisting of qualitative questions. Key experts were asked to identify and describe:

- The needs of youth and barriers to their accessing treatment.
- Best practice protocols, principle approaches and practices in each of the following substantive areas:
  - client outreach, contact and engagement;
  - client retention;
  - treatment values and philosophy;
  - treatment approaches (to address physical, mental, health and interpersonal issues);
  - relapse prevention;
  - structure of treatment (duration, intensity, organization);
  - integration of additional support services;
  - the most relevant, realistic and effective way of determining "success" for youth in treatment;
  - elements of a model treatment program for youth.

Key experts were given the opportunity to explore each question in depth, according to their own knowledge, expertise and background. Not all key experts responded to each question. In some cases, key experts requested a group interview. In one case, the key expert filled out the interview guide instead of being interviewed by telephone. Quotes from key experts are used extensively throughout this document to illustrate or enlarge upon key issues. Quotes retain the vocabulary and emphasis of key experts.

3.1.3 Interview Length and Process

Potential key experts were initially contacted by telephone. A fax was then sent explaining the background, purpose and content of the interview in more detail. The interviews ranged from 45 minutes to 2 hours in length; average interview length was approximately 1.25 hours. A fax was sent after the completion of each interview thanking participants for their participation.

3.2 Literature Review

3.2.1 Parameters of Literature Review

A focussed literature review was carried out in order to provide a research-based perspective on the specific topic areas defined above (an attempt was made to emphasize post-1990 literature). The literature review was based on sources that summarized research and evaluation results with the objective of identifying best practices. Sources included:

- surveys of youth treatment outcome data;
- comparison studies of programs using differing approaches or methods;
- program evaluation data.

A major reference source for this study was *The Nature and Treatment of Adolescent Substance Abuse* (Spooner, Howard and Mattick, 1996) published by the National Drug and Alcohol Research Centre, University of South Wales. This document includes extensive international reviews of the literature and analyses by subject area (causes and consequences of substance misuse, treatment outcome research and retention of clients in treatment) and results from consultations with treatment providers and clients.

It is recognized that some of the alcohol and drug treatment outcome literature is characterized by a range of methodological problems such as inadequate design, non-random assignment, lack of no-treatment control groups and poor client and substance use baseline data (Eliany and Rush, 1992). Where methodological problems are apparent these are cited; however, it was not possible to substantially critique the reliability or validity of the sources used.

3.2.2 Initial Literature Sources

A variety of resources, broad-based bibliographic and specialized bibliographic searches were used to produce the initial reference resources for the literature review. These included:

- National Clearinghouse on Substance Abuse: Specific bibliographic search on youth alcohol/drug treatment (Canada);
- National Institute on Drug Abuse: Annotated (topic-focussed) bibliography, NIDA research abstracts (bibliography);
- Addiction Research Foundation-Adolescent alcohol/drug problems and selected bibliography;
- Search of PREV line abstracts: National Clearinghouse for Alcohol and Drug Information;
- Search of NEDTAC (National Evaluation Data and Technical Assistance Centre);
- Uncover (Document Access Service): Key word search;
- Lindesmith Centre Library Database Search;
- A variety of generic studies produced by Health Canada and Canada's Drug Strategy Division.

4. Study Parameters and Definitions

4.1 Focus on Youth and Specialized Groups

The project focusses on barriers to treatment and best practices related to the treatment of substance use problems among youth between the ages of 12 and 21 years. These ages broadly reflect the intake criteria used by key experts within their programs and the literature on youth treatment.

While the project identifies barriers and outcomes related to youth in general, the report also discusses best practices in relation to the following groups with specialized needs:

- Aboriginal youth;
- youth from ethno-cultural minorities;
- youth who inject drugs/or living with HIV/AIDS;
- youth with concurrent substance use and mental health disorders;
- youth involved with the criminal justice system;
- youth who are marginalized, isolated or homeless.

With the exception of the barriers section (where key experts made specific comments related to sub-groups), key expert comments generally pertained to all types of clients. Where specific best practices relevant to the specialized groups are identified, these are noted in the text.

4.2 Definitions: Treatment and Best Practice

4.2.1 Treatment

For the purposes of this report, treatment is defined as "an organized set of approaches and strategies which assist clients to reduce or eliminate problematic use of alcohol or other drugs and which support healthy personal and interpersonal functioning." Although the term "drug and alcohol treatment" implies a single entity, in fact, it includes a complex and variable network of services.

As described in *Canada's Drug Strategy* (Health Canada), treatment and rehabilitation services in Canada include:

> . . . detoxification services, early identification and intervention, assessment and referral, basic counselling and case management, therapeutic intervention, aftercare and clinical follow-up. Treatment is offered on an out-patient, day-patient or in-patient basis, including short-term and long-term residential care. (Health Canada, 1998:9)

4.2.2 Definition and Scope of Best Practice

The definition of best practice as it relates to program delivery in the health field has been approached with varying degrees of rigour.

> Within health care, the application of the idea of "best practice" has ranged from simply publishing particular practices under the rubric of "best," . . . to engaging in a systematic identification of what would constitute "best" within a particular health issue or practice area, . . . to a rigorous research-based investigation to identify evidence associated with particular practices. (Varcoe, 1998:4)

In this project, best practice is defined as "a consensus of key expert opinion on the approaches and elements of treatment which appear to result in the most successful treatment outcomes for youth."

Best practice in this project is based on key expert experience, judgment and perspective. The related literature review provides a further support to the views and conclusions of key experts.

4.3 Definition of Consensus

Key experts identified a wide range of best practices in response to each survey question. However, only responses around which there was a consensus of opinion are included in this report. A "consensus response" was considered to be one where at least four key experts were in agreement. A high degree of consensus is indicated in the text. Some opinions and recommendations with less support around particular points are included if they illustrated or expanded upon a major theme.

Due to the open-ended nature of the questionnaire and the fact that answers were not probed to *achieve* consensus, numbers of key experts reporting (N) are not indicated for each response.

5. Project Limitations

5.1 Scope of Literature Review

The literature review provides an additional perspective on the topic areas defined in the study (Section 2.0). It does not provide a detailed overview of youth substance use patterns or characteristics, treatment needs or experience in treatment settings. While some general information is provided (e.g. on the variables associated with youth substance use problems), this information is provided only as context for the report.

The review revealed a number of gaps in the literature, particularly in relation to barriers to treatment engagement for the youth population. There was also a lack of empirically based research linking specific treatment approaches and methods with outcomes and effect. Within these topic areas, key experts contributed the primary information. There was also a lack of literature on the treatment needs and experiences of specific groups such as ethno-cultural minority or Aboriginal youth.

5.2 Topics and Groups with Special Needs Not Addressed in the Report

Several specialized groups (e.g. gay and lesbian youth, and youth with special needs) were not identified in the project's initial mandate and are not specifically addressed in this project. Reference was made by a number of key experts to the additional barriers experienced by and specialized treatment needs of gay and lesbian youth.

Two additional areas, relevant to youth treatment, were not addressed specifically by key experts and are considered only marginally in the literature:

- **The distinctive needs and effective approaches for treating male and female youth with substance use problems.** Youth treatment is still considered in a uni-dimensional way, although there is clear evidence that male and female youth have different developmental characteristics and needs. There are gender differences applicable to adult treatment (e.g. women appear to be more responsive to a "relational" model of treatment), but these have not been examined specifically in relation to young women. Spooner et al. (1996) noted that early studies suggest that while substance use patterns between male and female youth may be similar, females are more motivated and driven by interpersonal relationships and support than males.
- **Age group differences**. The literature and key experts do not differentiate between younger (11-14) and older (15+) youth, although cognitive and other developmental differences within these age groups clearly exist and would likely impact on treatment. Again, literature which addresses the implications of these age differences is lacking.

Section II: Results

6. Patterns of Youth Substance Use: Overview

6.1 Youth Substance Use Patterns

Youth substance use differs from that of adults not only in general patterns of use and substances used but in the meaning of and factors associated with use. A review of several studies of alcohol and drug use among adolescents and young adults (Harvey-Jansen, 1994; Hewitt et al., 1995; Weinberg et al., 1998; Adlaf et al., 1999; Faist and Health Canada, 1999b, 1999c) concludes that:

- alcohol, cannabis and tobacco are the drugs most frequently used by youth;
- gender differences in substance use are smallest among youth in comparison with other age groups;
- research during the last two decades has generally found a decrease in alcohol consumption among youth, although this trend may be reversing;
- regular heavy drinking (5+ drinks at a sitting) is most common among youth in late adolescence and early adulthood in comparison with other age groups;
- some surveys report an increase in heavy drinking among youth;
- alcohol and marijuana are the substances most likely to result in serious problems;
- use of marijuana increased sharply in the late 1990s after a generally declining trend over the last two decades based on both national and provincial/territorial surveys;
- use of other illegal drugs, such as cocaine, amphetamines, solvents and hallucinogens, appear to be increasing among youth;
- rates of heroin use are generally low;
- there is a low rate of medication use;
- the most frequently reported (and potentially addictive) medications used are stimulants and codeine, Demerol or morphine;
- among those who use drugs, multiple drug use is common;
- periods of drug/alcohol use tend to be short (due to age-related factors).

The Ontario Student Drug Use Survey[2] 1977-1999 (Adlaf et al.) found that rates of drug use which had been declining during the 1980s have now started to increase again. As the authors of this report note: "Since 1993, licit and illicit drug use has been on an upswing, to such an extent that in 1999 the use of only 2 of 16 drugs is significantly lower than it was in 1979." (Adlaf et al., 1999: iii).

Nova Scotia and New Brunswick[3] also report a trend toward increased use of illicit drugs by youth. For example, the percentage of students who use cannabis, medical or non-medical stimulants, psilocybin, mescaline, non-medical tranquillizers, cocaine or crack cocaine, PCP and heroin increased markedly, often doubling (from 1991 - 1998) (Province of Nova Scotia, 1998:4). In Newfoundland, although the total percentage of substance users did not change from 1996 - 1997 the proportion of poly-drug users increased (Newfoundland and Labrador Student Drug Use Survey, 1998). The Addictions Foundation of Manitoba Student Survey on Alcohol and Other Drugs (1997) found that while alcohol use among students has declined significantly, the use and acceptance of drugs other than alcohol is increasing.

6.2 Youth Substance Use Problems

Though in Canada, both national and provincial surveys indicate a generally declining trend in alcohol use among young people during the last two decades, use may now be increasing. In particular, rates of heavy drinking, intoxication or problem drinking have not shown the same decline (Adlaf et al., 1999, Health Canada 1999b, 1999c); for instance, the percentage of Ontario student drinkers consuming five or more drinks on a single occasion five or more times during the last four weeks increased from 3.9% of past year drinkers in 1995 to 7.1% in 1999; however, the survey did not find any changes in reported alcohol problems. In addition, in 1999 more students reported being unable to stop using drugs than in 1997 - 6.5% versus 2.9% (Adlaf et al., 1999). Nationally, the percentage of students who reported that they had been "really drunk" two or more times declined between 1990 and 1994; however, it rose again slightly between 1994 and 1998 for those in Grades 8 and 10 (Health Canada, 1999c). Among young women aged 20 to 24 years, the proportion classified as regular heavy drinkers almost doubled between 1994 - 1995 and 1996 - 1997 (Health Canada, 1999b).

Both national and provincial/territorial surveys have reported a trend of increased use of illegal substances, particularly cannabis. Use of cannabis is associated with other high-risk health behaviours such as drinking and smoking, having friends who use drugs, skipping classes and bullying (Health Canada, 1999c).

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2 The Addiction Research Foundation's (now Centre for Addictions and Mental Health) Ontario Student Drug Use Survey: 1977-1999 spans 22 years and is the longest ongoing study of youth drug use in Canada.

3 A comprehensive review of province-specific data was beyond the scope of the report. Data were primarily drawn from the Ontario Drug Use Survey and from several provincial student surveys from the years 1991-98.

Similar trends have also been found in the United States where data indicate that there was a sharp resurgence in substance use among youth in the 1990s. However, only a subset of users meet the criteria for substance misuse and dependence (1% to 3.5% identified in three national studies) (Weinberg et al., 1998).

However, there may be difficulties in defining what constitutes a substance use problem among youth when adolescence itself is characterized by change related to the achievement of significant developmental tasks, including:

- separation from the family;
- establishment of autonomy and identity;
- development of a personal value system (including a trend toward unconventionality).

For these reasons, some involvement in alcohol, drugs and tobacco is statistically "normative," particularly in late adolescence. Jessor noted that adolescence is:

> . . . a period in which a variety of behaviours relevant to health are initially learned and tried out—both those that are potentially health-compromising, such as drug use or precocious sexual activity, and those that are likely to be health-enhancing . . . . (Jessor, 1991:7)

Use patterns in adolescence may not be predictive of long-term substance use problems. George and Skinner (1991) found that recovery rates from early excessive drinking are high (73% to 88% for females, 55% to 80% for males). They identify two possible sub-groups among heavy or problem adolescent drinkers:

- a majority who will mature out of their excessive drinking often without formal intervention;
- a smaller number who are likely to progress to chronic alcohol dependence.

They suggest a similar pattern exists for youth using drugs other than alcohol.

Identification of this at-risk group is complex and is most typically identified by a multi-dimensional assessment of:

- the level and intensity of substance use;
- the impact of use on other personal, social and family relationships;
- the impact of use on health (George and Skinner, 1991; Wilkinson and Martin, 1991).

6.3 Factors Associated with Youth Substance Use Problems

An analysis of several broad literature reviews of youth treatment needs and effectiveness (Wilkinson and Martin, 1991; Spooner et al., 1996; Weinberg et al., 1998) suggests that the following factors are most typically associated with youth alcohol and drug problems:

- peer factors (may be less significant than previously thought) (Scheier et al., 1997);
- school-related factors;
- genetic and biological factors;
- gender (male sex);
- attitudes/personality traits/temperament (relationship of individuals to their environment, degree of isolation and/or powerlessness);
- identity issues (e.g. negative labelling);
- level of self-esteem;
- coping mechanisms for stress;
- macro-environmental factors (e.g. stress);
- mental health (there is a high degree of relationship between substance use problems and psychiatric disorders, including clinical depression, mood disorders, eating disorders, bipolar disorders and anxiety);
- cognitive dysfunction or difficulties with behaviour self-regulation (planning, judgment, self-monitoring as a result of youth's own direct use and exposure in utero);
- degree of knowledge;
- age of first use;
- relapse prevention, coping skills (focussing on urges or cravings);
- substance variables/composition and risk and attitude toward substances;
- parental use of alcohol and drugs;
- background of childhood physical and sexual assault;
- parental antisocial personality or psychiatric disorders (e.g. maternal depression);
- family stress;
- homelessness;
- socio-economic factors (although controversial, do appear to exert influence).

Although there is general consensus on the importance of these associated factors, some are controversial, subject to mediating variables or require more detailed exploration and analysis.

7. Summary Information on Specific Population Groups

Based on the available literature, this section provides a summary of general substance use patterns and treatment needs of specific population groups as defined in this study.

7.1 Street Involved, Homeless and Marginalized Youth

In this study, street youth are defined as those who live in transitory situations with no fixed (family) residence. Drugs and alcohol are typically used by street youth to cope with past family violence and the hardship of living on the street.

Although two studies of street youth in Toronto (1990 - 1992) suggest that illicit drug use among street youth might be declining[4], (Canadian Centre on Substance Abuse and Addiction Research Foundation, 1997), overall, street youth report high levels of alcohol/drug use in comparison with mainstream youth.

The most recent *Canadian Profile: Alcohol, Tobacco and Other Drugs, 1999* (Canadian Centre on Substance Abuse and Centre for Addiction and Mental Health, 1999) indicated that between a quarter and a half of street youth report frequent heavy drinking. In terms of other drug use, the percentage using cannabis ranges from 66% to 88%, and for cocaine from 18% to 64%. Street youth also have a much broader range of problems associated with heavy substance use, including employment, legal, psychosocial, educational and health problems (Smart and Ogborne, 1994).

Similarly in the United States, a review of four national studies (Greene et al., 1997) that explored the prevalence of substance use by runaway and homeless youth between the ages of 12 and 21, found drug use (marijuana, hallucinogens, cocaine, inhalants and intravenous drugs) consistently higher among street youth, whereas alcohol use was higher in non-street youth. Azrin et al. (1994) found that polydrug use was also significantly higher within the street youth population.

HIV infection is a serious risk for street youth because of drug use, needle sharing, unsafe sex practices, poor hygiene and lack of program resources. Rates of lifetime injection drug use among Canadian street youth range from approximately 11% in a national sample to 48% of males and 32% of females among Vancouver street youth (Canadian Centre on Substance Abuse and Centre for Addiction and Mental Health, 1999).

4 The study reported that between 1990 and 1992, a smaller proportion of Toronto street youth report using cannabis, LSD, cocaine, tranquillizers, speed, heroin or "Ice".

7.2 Ethno-cultural Minority

Extensive literature on use patterns among ethno-cultural minority youth is not available. A U.S. study (National Institute on Drug Abuse, 1995) on the incidence, prevalence, morbidity, mortality and health consequences of substance use among racial/ethnic populations concluded that Asian American youth generally report very low levels of substance use compared with other population groups. However, it is recognized that substance use problems within minority groups may not be reported due to cultural factors, racism in the mainstream society or lack of culturally appropriate programs (Longshore et al. as cited in Spooner et al., 1996).

Westermeyer (1997), in a survey of young refugees with substance use problems, found that this group of ethno-cultural minority youth was characterized by:

- a myriad of problems including psychiatric disorders, health problems, social withdrawal, violence and antisocial behaviours;
- family disruption;
- rapid course of disorder (increased use of substances over a short period of time);
- an emphasis on drug, rather than alcohol use.

7.3 Youth with Concurrent Substance Use and Mental Health Disorders

Although there are gaps in youth epidemiological research and problems with assessment of mental disorders, research clearly substantiates a high prevalence of concurrent substance use and mental disorders among youth (parallelling evidence in adult populations), although the construct of this relationship is not well defined.

In a review of population studies, clinical studies and studies of youth with psychiatric or substance use disorders in in-patient settings, Greenbaum et al. (1996) found that a substantial level of concurrent substance use and mental disorders was reported in *all* studies reviewed. Approximately half of all youth receiving mental health services were described as having a concurrent disorder. Among youth with concurrent disorders, conduct disorder and depression were the most frequent mental health disorders identified.

7.4 Youth Who Inject Drugs and/or are Living With HIV/AIDS, Hepatitis B and Hepatitis C

The biannual Ontario Student Drug Use Survey has reported on use of drugs by injection (Adlaf, et al., 1997). Between 1991 and 1997, the percentage of students injecting non-medical drugs during 12 months prior to the survey for the years 1991 to 1997 ranged from a high of 1.5% in 1995 to a low of 0.8% in 1997. The percentage who reported sharing needles in the previous year remained below 0.5% for all years. Rates of injecting and needle sharing are higher among street youth. A recent study in Montreal found that 36.1% had injected drugs in their lifetime, and of these 58% had shared needles (Roy, 1999).

In Canada, AIDS is rare among youth. As of December 31, 1999, 0.4% of reported AIDS cases were adolescents (10 - 19 years) and 15.7% were diagnosed in young adults (20 - 29 years); given the length of time between initial infection and diagnosis of AIDS, the latter group may well have been infected as teenagers (Health Canada, 2000). Among younger adolescents (10 - 19 years), AIDS is almost entirely associated with exposure to infected blood or blood products. However, among those in the 15- to 19-years-old age group, 4% was attributed to injection drug use and a further 4% to men having sex with men/injection drug use. The same pattern also holds true for HIV (Health Canada, 2000).

One study of street youth in Canada reported rates of infection of 3.9% for HIV, of 26.5% for hepatitis C, and of 16.2% for hepatitis B.

7.5 Aboriginal Youth

According to *Canadian Profile 1997* and *1999* (Canadian Centre on Substance Abuse and Centre for Addiction and Mental Health, 1997, 1999), Aboriginal youth:

- are at two to six times greater risk for every alcohol-related problem than their counterparts in the general population;
- use solvents more frequently than other Canadian youth. One in five Aboriginal youth has used solvents; one third of all users are under 15 and more than half of all solvent users began use before age 11;
- are more likely to use all types of illicit drugs (First Nations and Métis youth) than non-Indigenous youth;
- begin using substances (tobacco, solvents, alcohol and cannabis) at a much earlier age than non-Aboriginal youth.

Aboriginal youth are also over-represented in many of the populations most vulnerable to HIV infection, such as inner city populations, sex-trade workers and incarcerated populations.

7.6 Youth Involved in the Criminal Justice System

There appears to be a strong relationship between youth substance abuse and direct involvement in the criminal justice system, although the nature of this relationship is not clear. In a study of 847 youth from 11 substance abuse programs in Ontario, Smart and Ogborne (1994) found that:

- 48% of street youth and 36% of non-street youth were on probation/parole/bail or awaiting trial;
- 30% of street youth and 16% of non-street youth had been in a correctional establishment in the past six months.

A review of 121 youth referred for individual and group out-patient addiction counselling in Toronto (83% of all referrals in a six-month period) found that 50% of the sample had been involved, at some level, with the justice system, with 18% of the sample mandated to treatment by the courts (Ogborne, 1997).

Many youth involved in the criminal justice system are affected by Fetal Alcohol Syndrome (FAS) and other alcohol-related effects. A study of 287 youth in British Columbia referred for a forensic psychiatric/psychological assessment in the juvenile justice system (1995 - 1996) found that 23.3% were affected by FAS or related disorders (Fast et al., 1999).

Youth with substance use disorders who are also involved in the justice system often manifest:

- multiple (socio-economic/psychological/behavioural) problems;
- chaotic social backgrounds, with limited education and family support (Kosky et al. cited in Spooner et al., 1996);
- low motivation or ambivalence toward treatment, if treatment is mandated;
- problems with violence which may make treatment participation difficult.

8. Barriers to Treatment

8.1 General Barriers to Treatment: Key Expert Perspectives

Key experts described three types of barriers which affect or limit youth access to treatment:

- **Personal barriers** related to the youth's perception of self, lack of knowledge or presence of co-existing personal problems;
- **Barriers related to family and peer relationships**;
- **Structural or program-related barriers**.

8.1.1 Personal Barriers

The primary personal barrier (identified by 16/28 key experts) is a lack of recognition and denial of a substance use problem. "Denial" was described by respondents as including the youth's:

- inability to identify a problem because he/she is convinced that her/his behaviour is normative, and simply part of adolescent development;
- inability to identify problems because of an inability to conceptualize issues or use abstract thought;

- fear of exploring more profound issues underlying substance use problems (e.g., sexual or emotional abuse);
- feelings of invincibility and "knowing it all;"
- tendency to minimize serious problems.

A second personal barrier described by key experts is the lack of trust and the presence of mental health and personal problems (e.g. low self-esteem, depression, the presence of learning disabilities and concurrent psychiatric or mental health disorders) which mitigate against defining the need for, or the ability to access, treatment. One key expert noted that youth experiencing long-term physical, sexual or emotional abuse may become numb and lack the motivation to access treatment. They use alcohol and other drugs to cope with their personal situations and feel there are no other options.

Finally, key experts noted that youth are often isolated and do not understand what programs are available, how they are organized and what they might offer. When this general lack of awareness is linked to poor program outreach, little contact results.

8.1.2 Barriers Related to Family and Peer Relationships

Three family-related barriers were highlighted by key experts. First, youth may have parents with their own alcohol/drug problems which affect their ability to support or access treatment for their children. Secondly, parents may be unsupportive or not be willing to be involved in treatment because they deny the extent or severity of their child's substance use. Thirdly, according to key experts, family breakdown and/or abuse may result in dysfunctional family relationships where parents lack ability to influence youth decision making.

Negative peer culture (peer values and relationships) was identified as being a strong barrier to youth seeking alcohol or drug treatment. Peer activities and values may "normalize" alcohol and drug use to the degree that acknowledging or understanding the negative impact of alcohol/drug use becomes difficult. Youth culture provides an alternative to adult control and authority even in circumstances where prevailing values are negative.

8.1.3 Structural and Program-Related Barriers

More structural/program barriers were identified by key experts than personal and family barriers. There was also more consensus on the program-related barriers which limit youth access to treatment. The following program/structural barriers were identified:

- There is a general lack of programs across Canada specifically oriented to the unique needs of youth.

- Existing programs are often inaccessible, particularly to youth living in isolated or remote geographic or population areas.
- There is a lack of workers skilled in counselling youth.
- There is poor outreach and lack of accessible, community-based information on treatment for youth. They often do not know what kind of treatment is available or what it can achieve.
- There is a specific lack of residential treatment available to those youth who need an intensive and highly structured environment.
- Programs often have lengthy waiting lists which discourage timely treatment.
- High costs (e.g. transportation) may limit access to treatment.

For many key experts, issues of program *availability* still remain the primary barrier to treatment for youth:

> *Our problem is a lack of resources – meat and potato programs for all youth and cornerstone programs for street youth.*

***

> *We have an epidemic in our province but less than 20 (funded) residential beds.*

Table 4: General Barriers: Key Expert Perspectives

Primary Personal Barriers	Primary Family-Related Barriers	Primary Structural/ Program Barriers
▪ Denial/lack of recognition of problem ▪ Peer values and group membership normalize use ▪ Personal issues which mitigate against access (self-esteem, mental health and cognitive problems) ▪ Lack of awareness of treatment options	▪ Parental abuse ▪ Parent substance use problems ▪ Lack of parent support/denial ▪ Family breakdown	▪ Lack of youth-oriented programming ▪ Long waiting lists ▪ Lack of accessibility to existing programs ▪ Lack of workers skilled in counselling youth ▪ Poor outreach information ▪ Lack of specialized residential treatment

8.2 Barriers Experienced by Specific Groups

Key experts were asked to identify barriers related to groups with specialized needs. Many of the barriers identified were the same as those identified for youth in general, although specific emphasis on barriers varied from group to group. In most cases, program-related or structural barriers received the most emphasis.

8.2.1 Street-Involved, Homeless and Marginalized Youth

Key experts noted that street-involved, homeless youth and marginalized youth experience all the barriers identified for youth in general but in a more intensive form. Homeless or street-involved youth do not traditionally self-refer to programs and are unlikely to be familiar with access points or the process of referral. Highly stressful living conditions (e.g. poverty, lack of adequate housing) and concurrent substance use and mental health disorders also make self-referral problematic. Street-involved/homeless youth also have a higher degree of distrust and hostility toward mainstream institutions and typically lack family support to assist with treatment access, costs or planning.

On a program/structural level, key experts identified the following factors as barriers to this group:

- a lack of immediate accessibility to (24-hour) services including access to safe detoxication services;
- restrictive treatment entry requirements which may be difficult for street-involved youth to meet;
- a lack of adjunctive services, such as safe and secure housing, which are prerequisites to effective treatment utilization.

> *Youth need a secure living environment. It is hard to access a day program when youth are not feeling safe where they're living.*

8.2.2 Youth with Concurrent Substance Use and Mental Health Disorders

Key experts identified structural/program barriers, specifically poor integration and coordination between the mental health and substance abuse treatment systems, as the most significant barrier for this group. This lack of integration is related to differences in each system's philosophy, role definitions and approach. Respondents described the relationship between the two systems as being characterized by:

- "cultural" misunderstandings based on different interpretations of and prioritization of needs;

- disagreement between mental health and substance abuse treatment staff on "what needs to happen first" for the client;
- a lack of staff with "cross-over" skills;
- a lack of child psychiatrists accessible to the substance abuse treatment system;
- a lack of coordination between services/youth "flip-flop" between the two systems;
- limited substance abuse treatment program content responsive to the mental health needs of clients and vice versa;
- a lack of coordinated case management/poor definition of roles, structure and process.

Key experts also identified the substance abuse treatment system's lack of ability to generate comprehensive diagnoses to assist staff in the effective delivery of treatment, the lack of staff trained to handle both substance use problems and mental health issues, and the lack of specialized programs with the capacity to treat clients with both types of problems.

8.2.3 Youth Who Inject Drugs

Key experts described many barriers to treatment experienced by youth who inject drugs and those living with HIV/AIDS. Two primary personal barriers were emphasized:

- the isolation and general marginalization of youth who inject drugs and distance (emotional/physical) from mainstream systems;
- a high level of distrust and hostility toward the mainstream system which makes disclosure of problems difficult and makes youth who inject drugs reluctant to participate in treatment.

No familial/community barriers were noted. However, a number of program/structural barriers were identified. These centred on two themes:

- the lack of accessible and effective methadone maintenance programs for older youth and for those who require or qualify for this form of treatment;
- the lack of specialized services which recognize the distinctive needs of youth who inject drugs and/or those living with HIV/AIDS.

Respondents noted that youth who inject drugs are characterized by multiple problems and a sense of "apartness" strengthened by behaviours sometimes seen as ritualistic. HIV/AIDS victims are more severely marginalized and have little in common with other youth in treatment. Programs need to be able to meet practical needs (e.g. to supply clean needles) initially without putting too many restrictions or "conditions" on early stage treatment access or assistance.

8.2.4 Ethno-cultural Minority Youth

Several personal, family and structural/program barriers experienced by ethno-cultural minority groups were identified by key experts. The primary personal barrier was described as a set of cultural beliefs within many ethno-cultural minority cultures which discourage the acknowledgement, exploration and addressing of alcohol and drug-related problems. Within the Asian culture, for example:

> *There is greater stigma attached to (alcohol/drug) problems . . . they don't take their problems outside the culture.*

Cultural traditions may support youth receiving help from informal (culturally supported) networks rather than from external (community-based) resources. Families may reinforce this pattern by discouraging approaches to outside resources or not understanding the needs of their children. In some cases, this misunderstanding is reflected in inter-generational conflict.

A lack of worker sensitivity and a lack of cross-cultural skills and training were also described as barriers for this population. Language is seen as another barrier to accessing services and resources. Parents, and sometimes youth, may not be familiar enough with English or French to support or participate in treatment. Key experts also identified a lack of culturally responsive outreach to minority communities as an additional barrier. Effective approaches include the following elements:

- outreach must be directly "on the street;"
- use specific ethno-cultural approaches;
- take into account language barriers.

8.2.5 Aboriginal Youth

Key experts identified familial/community and program/structural barriers for Aboriginal youth. Language barriers were identified by a number of key experts. Language problems may be particularly acute for parents, thus preventing them from participating in their child's recovery. Many Aboriginal youth were also described as coming from a more problematic substance "use" environment. Responding to alcohol abuse may be more difficult within certain Aboriginal communities.

Key experts also mentioned that youth treatment programs are often not supported in the Aboriginal community and that parents often do not request assistance due both to community factors and their own history of abuse or family breakdown. There was strong consensus that treatment programs are

often alienating or not culturally appropriate for Aboriginal youth. Elements of cultural appropriateness were identified by some respondents. Elements include:

- appropriate language;
- inclusion of a spiritual component (beliefs and practices) in treatment;
- Aboriginal staffing;
- culturally appropriate outreach;
- connection of Aboriginal youth to Aboriginal social service systems and support.

8.2.6 Youth Involved with the Criminal Justice System

Key experts described youth involved in the criminal justice system as the group most likely to be resistant to treatment (which is often mandated), due to lack motivation[5], and as having little or no support from family. Structural barriers identified by key experts include the following:

- A lack of treatment available in either the justice or substance abuse treatment systems. The correctional system typically does not provide treatment and the substance abuse system may not make treatment accessible to juvenile offenders, particularly if legal issues are unresolved.
- Correctional workers may lack knowledge and understanding of treatment options and not make referrals to appropriate community-based programs.
- The "closed culture" of juvenile offenders which makes group treatment difficult. This culture is characterized by secrecy and group loyalty.

> *These are in many ways, our toughest kids. They are system-wise and know how to fulfil requirements but don't learn (what they may need to change).*

5 Although several key experts noted that mandated youth may be "relieved" to have to face substance abuse issues.

Table 5: Barriers to Treatment: Youth with Special Needs: Key Expert Perspectives

Group	Personal Barriers	Family/ Community	Program/Structural
Street-involved youth	▪ Don't self-refer ▪ Multiple problems ▪ Distrust of mainstream system ▪ Don't understand access points	▪ Lack of support from family and significant others to access and use treatment	▪ Lack of effective outreach programs ▪ Lack of service flexibility ▪ Restrictive treatment entry ▪ Lack of adjunctive services (e.g. housing) which support treatment
Youth with concurrent substance use and mental health disorders	▪ No consensus among key experts	▪ No consensus	▪ Lack of planning, coordination and understanding between mental health and substance abuse treatment systems ▪ Inadequate early diagnoses or capacity to provide them ▪ Insufficient number of programs to handle specific needs of clients ▪ Lack of trained staff who can treat both types of problems
Youth who inject drugs	▪ Multiple barriers ▪ Isolation and marginalization from society ▪ Distrust/hostility toward mainstream system	▪ General isolation and lack of supportive relationships	▪ Inadequate/inaccessible methadone maintenance treatment ▪ Lack of understanding of specialized needs ▪ Need to have practical needs addressed prior to and concurrently with substance abuse treatment needs
Ethno-cultural minority youth	▪ Cultural beliefs strengthen denial and avoidance of problems ▪ Greater stigma attached to drug/alcohol problems	▪ Families may deny problems ▪ May not support treatment/look to internal problem solving or own community ▪ Inter-generational misunderstanding and conflict	▪ Lack of culturally appropriate outreach ▪ Language barriers, especially parental language barriers ▪ Lack of worker sensitivity or cross-cultural skills and training
Aboriginal youth	▪ No consensus	▪ High level of substance use in some Aboriginal communities ▪ Youth treatment may not be supported/seen as appropriate ▪ Families do not request assistance	▪ Language barriers (including parental language barriers) ▪ Lack of culturally appropriate programs
Youth involved with justice system	▪ Resistance to mandated treatment ▪ Peer culture	▪ Often no support from family	▪ Lack of correctional programs addressing substance use problems ▪ Barriers to accessing community programs ▪ Group work difficult with offenders ▪ Corrections staff lack knowledge of substance abuse treatment system - often don't refer youth with substance use problems

8.3 Barriers to Treatment: Literature Review

There is little literature specifically related to barriers experienced by youth, especially within the sub-groups identified in this study. This is partially because treatment entry within the youth population is based to a greater degree on non-voluntary access where personal barriers may be less of a factor. Key experts cited a range of issues related to denial or fear of acknowledging substance use problems as primary barriers to treatment. Homel (as cited in Spooner et al., (1996) also explored the issue of denial. In a study of illicit drugs users, ages 16 - 21, he found that "adolescents were using substances at a frequency that was quite likely to be affecting their ability to function productively in society, but that this was *not* viewed as a problem." Instead, the participants' definition of a problem was " . . . that dependency was so great they could not stop using" (Spooner et al., 1996:3 - 15).

Instead of asking youth whether they had a substance abuse problem, Bungey and Faulkner (as cited in Spooner et al., 1996) asked youth whether their substance use had created problems for them in the previous 12 months. This question prompted the respondents to report many personal, legal, financial, work and relationship problems. This study suggests that youth can identify specific problems related to substance use but are less willing to consider substance use *itself* a problem.

The literature supports the relevance of the following factors which key experts defined as barriers to treatment, e.g. the co-occurrence of psychiatric disorders and risk factors (Bukstein et al., 1989; Weinberg et al., 1998;) association of peer influence (Spooner et al., 1996) and presence of childhood victimization (Blood and Cornwell, 1996). However, in the literature, these characteristics were not clearly defined as barriers to treatment access but as factors influencing treatment outcome.

9. Best Practices: Treatment Outreach, Contact and Engagement

9.1 Treatment Outreach, Contact and Engagement: Key Expert Perspectives

Key experts described a number of best practices related to the outreach, contact and engagement of youth in treatment. Key expert comments were categorized into four general areas:

- Location and physical accessibility of treatment;
- Program approach and philosophy;
- Program outreach strategies;
- Program structure and content.

9.1.1 Program Location and Physical Accessibility

Key experts identified the importance of direct staff outreach to all community locations where youth assemble (malls, schools, street, mental health centres, clubs, recreational facilities). A strong liaison with and presence within schools was emphasized:

> *With marginalized youth, don't expect them to come in, you must go out to the malls, arcades, drop-in centres, schools.*

It was emphasized that "outreach" does not simply describe a geographical location but implies a certain kind of staff - client relationship.

> *Street workers are on the level of street youth; workers show they care and can meet practical needs.*

Substance abuse programs need to develop long-term collaborative and supportive relationships with those in the community who work directly with youth, primarily school staff. Respondents identified the importance of programs being accessible at some level (e.g. through a drop-in component) to youth *as needed*. Youth should be able to access some level of services at any time and not be restricted by office hours. This is particularly important for street-involved youth. Respondents also noted that there should be few restrictions on initial stage entry to services. Exhibiting violent behaviour would be one of the few admission restrictions that would require referral to a more specialized program able to address the needs of youth with severe behavioural problems.

9.1.2 Program Approaches and Philosophy

Key experts described a number of elements of best practices related to program approach and philosophy. These are:

- an accepting, respectful and non-judgmental approach to youth;
- familiarity with youth reality and language;
- treatment goals and purpose to be determined by youth and youth needs (client centred);
- the importance of establishing a physically and emotionally secure environment for treatment (where youth feel protected, comfortable and where their basic needs are met).

9.1.3 Program Outreach Strategies

Many other professionals (school teachers and counsellors, mental health workers, street workers) are the first point of contact with youth. Key experts stressed the need for program staff to provide training and maintain supportive/collaborative relationships with these workers in order to facilitate treatment access. Key experts also identified a need for programs to incorporate strategies to facilitate access to supportive family members, even prior to contact with youth.

> *Often a parent or friend calls on behalf of the youth, and agencies should be willing to see those people, maybe even without the youth for the first time.*

***

> *Our program sends a letter of orientation/invitation to parents of all youth associated with the youth program.*

9.1.4 Program Structure and Content

There was strong consensus on two elements of treatment content which support client engagement.

- The importance of immediately engaging youth through the provision of diverse recreational activities which are enjoyable and non-threatening and which establish trust and positive client-staff relationships.

  > *We do initial out-trips (kayaking) using a key worker with one or two youth. We get them on the road, assist with detox, engage them and then move them into counselling.*

- The importance of developing and supporting school-based or community prevention activities as a less threatening "window" through which youth can enter treatment.

Table 6: Best Practices Related to Treatment Outreach, Contact and Engagement: Summary of Key Expert Perspectives

Area of Best Practice	Respondent Themes
Program Location/Access	▪ Direct staff outreach to youth-defined venues ▪ Develop long-term, highly supportive staff-client relationships ▪ Support program/school relationships ▪ Provide immediate (24 hours) access to youth ▪ Use community prevention programs as building block to access ▪ Low threshold to access (few entry criteria)
Outreach	▪ Drop-in component to support access ▪ Maintain extensive referral networks ▪ Train referral sources ▪ Involve family members prior to contact with youth, if desired
Approach/Philosophy	▪ Respectful, non-judgmental staff ▪ Familiarity with youth reality and language ▪ Client-centred treatment ▪ Establish safe, secure, comfortable treatment environment
Program Structure/Content	▪ Include recreational activities (fun, and non-threatening) ▪ School and community-based prevention activities

9.2 Treatment Outreach, Contact and Engagement: Literature Review

There is a lack of specific literature addressing aspects of treatment which support initial client engagement in treatment. Spooner noted that:

> Services tend to be unattractive to adolescents: adolescents are fearful of most services, the staff members and what they will do to them. This acts as a barrier to seeking treatment and, once in, adolescents do not want to stay in services that they do not like or do not feel comfortable in. (Spooner, 1996:29)

Spooner concluded that the physical setting for treatment must be attractive and non-clinical and the atmosphere relaxing, informal yet vibrant. Brown noted that treatment facilities designed to serve adults may project a clinical ambience which deters young clients. He also stated that:

> Emphasis on making and keeping appointments should be replaced with a working format which allows young people to visit without notice to obtain some services. (Brown as cited in Spooner, 1996:39)

A study by Aquilar and Munson (1992) supports the utility of leisure and recreation as intervention and treatment strategies for youth with drug/alcohol use problems; however, it does not link these findings directly with client engagement in treatment.

10. Client Retention in Treatment

10.1 Client Retention in Treatment: Key Expert Perspectives

10.1.1 General Comments

The literature suggests that retention of clients in treatment is an issue within a range of health-related services, including substance abuse treatment. It is generally accepted that clients who drop out of treatment early have a much greater likelihood of returning to problematic substance use (Stark as cited in Spooner et al., 1996). At the same time, there is a recognition that treatment drop-out is "normative" across all treatment modalities and that benefits may still accrue to short-term treatment involvement. Youth present a special case in treatment because they:

> Tend not to voluntarily use treatment services. Most are coerced by their family, schools, the legal system or significant others. Often adolescents see treatment as unapproachable, irrelevant, frightening, distasteful or not very useful. (Spooner et al., 1996:72)

Some key experts involved in this study were critical of the concept of retention, believing that it is a "static" approach which does not reflect youth reality.

> *Youth are going through a process—a program doesn't have to retain them to be successful.*

***

> *Youth will return to a program while they are getting something out of it—programs need to honour that leaving is part of process.*

Key experts identified best practices related to retention in the following areas:

- assessment and intake;
- program philosophy and approach;

- family outreach and involvement;
- program content;
- needs of specialized groups.

10.1.2 Assessment and Intake

Two aspects of assessment and intake were identified as best practices which support the retention of youth in treatment:

- The importance of (early stage) client/treatment matching, which considers and tries to match client readiness with treatment objectives and methods. Several respondents recommended the "Stages of Change" model as a tool to assist with client/treatment matching.

  > *We need to match treatment to the stage youth are in, for example, we can't do treatment if youth are in the pre-contemplative stage.*

- The importance of making available, both to the client and family, at intake detailed information about the program, presented in creative and interesting ways.

  > *They get a booklet called "Welcome to ____" and it explains everything, such as phone privileges. There are no surprises.*
  >
  > ***
  >
  > *We have a one-day treatment workshop for (treatment) resistant kids – they do role plays, have a pizza, do an evaluation and sometimes the kids see that it is not so bad to go here.*

10.1.3 Program Philosophy and Approach

There was a strong consensus among key experts that both an understanding/acceptance of relapse and a focus on harm reduction are the optimal approaches to support youth retention in treatment. This dual approach (acceptance of relapse/use of a harm reduction model) was described in varying ways but appears to include these common elements:

- acceptance of youth relapse as an inevitable part of recovery;
- consideration of relapse not as a failure but as an opportunity to learn about substance use triggers and ways of reducing use;
- a need to focus on client life goals and the impact of substance use on these rather than primarily focussing on substance use;

- the development of a long-term supportive client - staff relationship which accepts and explores relapse;
- the presence of program strategies to support youth re-engagement in treatment, if and when relapse has occurred.

Coupled with this dual approach was strong key expert consensus on the value of a client-directed approach which supports client involvement in goal setting and treatment planning.

> *We set up a contract with the kid – s/he determines what to work on (like reduction in use or coping with family), what their indicators of success would be, frequency of sessions – this makes them feel in control.*

A flexible approach to treatment outcome was also stressed. Treatment "success" is not always straightforward. Needs vary and youth learn at their own rate.

> *For various sub-groups of youth, structure and duration may vary – don't need to do anything different than allow youth to work at their own rate.*

Finally, a respectful and supportive staff approach to clients was described as one of the most significant factors supporting retention of youth in treatment.

> *Don't rely on academic therapy if you truly value youth and believe in them and see them as really neat, bright survivors – really respect them, that goes a long way with them. Gets them to come in and to work. If they feel valued, then they feel valuable and will want to work on themselves.*

10.1.4 Outreach to Families

There was broad consensus among key experts on the importance of actively involving the family in treatment. The engagement of even one family member (a sibling or one parent) is considered critical. It is recognized that families often have diverse needs (for therapy, education or support) which programs need to address. Sometimes early work with parents is the entry point for youth treatment.

> *We may work for one and a half years with parents or adult figures in a youth's life and hardly ever see the kids.*

10.1.5 Program Content

Key experts identified a broad psycho-educational approach as the most optimal way of retaining youth in treatment (see Section 12.0 for more detail on treatment approaches). Coupled with this broad approach is the importance of providing a treatment environment that is safe, fun and which incorporates a range of recreational activities.

10.1.6 Needs of Specialized Groups

In most cases, general key expert comments also applied to youth in specialized sub-groups. However, several comments were made specifically related to these sub-groups. There was key expert consensus that:

- **Street-involved youth/Aboriginal youth** require, above all, a safe and secure treatment environment.
- **Aboriginal youth** require programs which incorporate traditional beliefs and practices from the Aboriginal community. There is a need for a component of treatment which addresses spiritual needs, practices and beliefs.

Table 7: Client Retention in Treatment: Key Expert Perspectives

Areas of Best Practices	Summary of Key Expert Perspectives
Assessment and intake	▪ Importance of appropriate client/treatment matching (e.g. intervention matched to Stages of Change model) ▪ Availability of concrete (early stage) information about the program
Program approach	▪ Harm reduction model ▪ Flexible, open-ended approach ▪ Respectful, supportive and engaged staff ▪ Understanding/acceptance and management of relapse ▪ Focus on broader life goals ▪ Staff able to re-engage youth in treatment if relapse occurs
Family outreach	▪ Family involvement (at early stage) ▪ Assessment and addressing of diverse family needs
Program content	▪ Broad psycho-educational approach ▪ Culturally appropriate activities ▪ Recreational component ▪ Safe environment ▪ Fun, creative

10.2 Retention in Treatment: Literature Review[6]

There is little available youth-oriented literature which specifically addresses treatment retention. However, retention issues are often addressed when considering treatment approaches, methods or effectiveness. Within the adult-oriented literature, the main predictors of retention include a mix of demographic, family and program variables. Spooner et al. (1996) summarized the factors most closely related to client retention in treatment.

- age;
- level of education;
- type of psychopathology (e.g. depression);
- degree of support from family and friends;
- level of prior substance abuse;
- living arrangements (whether stable or unstable).

A number of treatment program elements have been associated with (continued) retention in treatment (for adults). These include:

- continuous progress review and assessment;
- attention to psychological issues;
- attention to family needs;
- individual attention;
- increased attention to newer treatment clients (in residential settings) (Condelli and De-Leon as cited in Spooner et al., 1996).

Miller (as cited in Spooner et al., 1996), in a compilation of staff opinions, identified the elements of a program most likely to retain youth clients. The elements included high levels of support for client spontaneity, support for client activity and growth and autonomy, a practical and personal problem-solving orientation and encouragement for expression of feelings. A reasonable level of order and organization, program clarity and staff control (to ensure clients' safety) were also described. A safe environment was also thought to be applicable to longer-term retention.

Schonberg (as cited in Spooner et al., 1996) noted the importance of careful client/treatment matching in order to retain clients in treatment. Client treatment involves an assessment and weighing of multiple factors such as level of toxicity, withdrawal effects, consideration of medical, intrapersonal, interpersonal and environmental issues.

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6 Retention issues are also covered in Section 12.

11. Treatment Principles and Values

11.1 Treatment Principles and Values: Key Expert Perspectives

Key experts identified 12 philosophical principles or operating values which they believe underlie successful youth treatment. Some of these have already been addressed (Section 10.0). They were described as being applicable to all youth in treatment.

Table 8: Treatment Principles and Values: Key Expert Perspectives

Principle	Key Expert Comments
1. Treatment planning and delivery should be highly individualized, client-centred and client-directed. Tools like the "Stages of Change" model and motivational interviewing support this approach.	▪ Go where, start where and respect where youth are at. ▪ Treatment must be designed to meet individual treatment plans and to support residents to achieve goals.
2. While there is sometimes a struggle between the "harm reduction" and abstinence models, the harm reduction approach is most effective with and responsive to youth needs and stage of life. Teaching youth to "keep themselves safe" is the "cornerstone" of this approach.	▪ Keep the kids as safe as possible in terms of harm reduction. ▪ If they are going to use, teach them how they can use safely. ▪ Most individuals mature out of addiction. Provider's job is to ensure they come out of their addiction unharmed and intact.
3. Treatment should offer and be based on choice. A multi-dimensional, eclectic model is preferable to one which is based on an uni-dimensional treatment approach.	▪ Treatment providers must be cognizant of all approaches available – and move to one or another, if needed. ▪ Offer a menu of opportunities.
4. Treatment should consider youths within a *system* – of family, peers, community and others (school teachers, counsellors and correctional staff).	▪ Kids must be linked to all members of their community, for example, elders. ▪ Listen very carefully to what the client says about the community and who they feel the workers in the community are that they respect.
5. The climate of treatment should be caring, respectful, safe and open.	▪ In our program, there is no issue that cannot be brought to the table. ▪ Give them a sense of community, living in a safe place, offering unconditional love. ▪ Respect and treat them as human beings.
6. Wherever feasible, families should play an important part in treatment. If there is no current "stable" family, a family of "significant" adults should be created.	▪ Family has to be involved, and if youth has no family, you create one – a "family of choice." People from the community are chosen by youth to be family.

Table 8: Treatment Principles and Values: Key Expert Perspectives (cont'd)

Principle	Key Expert Comments
7. Treatment needs to consider the youths' spiritual, mental, emotional and physical self and needs.	▪ Must give these kids spiritual guidance. ▪ Have them attend sweat lodge and sundance traditional ceremonies.
8. Programs should espouse the principle of "least intrusive treatment" as a first option (based on appropriate assessment and treatment matching).	▪ A mistake is to impose a heavy-handed, highly intensive program at the early stage.
9. Staff must respect and value youth in treatment, trusting in their basic motivation and value.	▪ Kids are okay, they may screw it up, but they'll work it out. ▪ Help youth create a "thicker" story of themselves – that *they are valuable, will get a job.* ▪ Show other ways of looking at self.
10. Wherever possible, learning should be experiential and be conducted in a variety of venues.	▪ Use activity-based treatment (for example, martial arts and sports) in community, exploring their interests and pushing them further to develop their interests.
11. Treatment should focus on positives, not deficits in the youth's life. The "Resiliency Model" is a useful approach.	▪ Focus on positives, not what needs fixing. Identify, focus and build on youth's positive strengths. ▪ Avoid deficit thinking – build on skills already there. ▪ Do not label as an addict – doesn't *give room to grow.*
12. Treatment should focus on the building of specific skills which enhance self-esteem.	▪ A key objective is to enhance child's competence in different aspects of his/her life that will help him/her become a good decision maker. ▪ Provide youth with a toolbox to help them understand what they need to do for self, how (they) can make responsible decisions re: setting goals and achieving them.

11.2 Treatment Values and Philosophy: Literature Review

Spooner et al. (1996), in a comprehensive review of the literature on youth substance abuse treatment, coupled with extensive community and client consultation, identified three baseline principles of treatment directed towards youth. In the view of Spooner and colleagues, effective programs should:

- **Be holistic and comprehensive.** Address a variety of problems (e.g. practical problems, childhood abuse) with a range of strategies (counselling, skill training, support and referral);

- **Encompass harm reduction**. While abstinence is still a useful goal, most youth are unwilling to change their lives fundamentally; therefore, long-term abstinence is likely to be unrealistic. Even where abstinence is a goal, *harm minimization* strategies are required;
- **Be appropriate for youth.** Youth needs and experiences differ fundamentally from those of adults. An adult-oriented approach to treatment should be avoided.

Spooner and colleagues (1996) also identified other treatment principles or values, including the importance of:

- basing treatment on the developmental stages and needs of the youth;
- seeing treatment as a process, not a series of events;
- understanding that the use of substances has a function for youth. Training in skills development and coping strategies should address these needs;
- involving youth in the development, implementation and review of program rules and boundaries;
- avoiding negative labels for youth in treatment;
- designing a collaborative treatment system which takes pressure off youth to identify and access a range of resources for themselves.

Many of these summary comments are reflected in the best practices principles described (Section 11.1) by key experts.

A review of outcome-based research by Catalano et al. (1990 - 1991) supports the value of family support in treatment and the efficacy of skills teaching. A literature review on adolescent alcohol and drug treatment effectiveness by Faist and Harvey-Jansen (1994) also identified the following approaches which support the principles outlined above. This study stressed the importance of:

- flexible treatment;
- formalized assessments resulting in appropriate client/treatment matching;
- family involvement in therapy;
- the offering of a range of ancillary support services.

A broader study by Chinman and Linney (1998) identified the "empowerment model" as one that may be useful in improving youth outcomes in a variety of prevention and intervention settings. The empowerment model includes many of the optimal treatment values identified by key experts such as:

- a focus on youth strengths, not deficits;
- a collaborative (client-centred) approach to prevention and intervention;

- a focus on skill development which supports self-correction;
- the use of a developmental theory of change (new insights and abilities lead to new awareness which leads to new choices);
- the valuing of crisis and conflict as impetus for action and change;
- the use of empowerment language;
- the presence of supportive channels (activities, community participation) to support.

12. Treatment Approaches and Methods

12.1 Treatment Approaches and Methods: Key Expert Perspectives

Key experts were asked to identify effective treatment approaches and methods which address the major issues of youth with substance use problems. Approaches and methods were explored in relation to the following areas of need:

- health problems of youth in treatment (e.g. eating disorders);
- personal issues such as mental health, self-esteem and needs arising from developmental changes;
- interpersonal issues of importance to youth (family and peer relationships);
- relapse management/prevention.

12.1.1 Treatment Approaches to Address Physical Health Issues

Substance abuse impacts directly and indirectly on the health of users, although the substance abuse literature primarily addresses long-term effects on adults. Health impacts vary according to the substances used, dose, frequency and duration of use, manner of (substance) administration or results of use.

Health-related problems associated with alcohol/drug use in youth and adults (summarized by Spooner et al., 1996) include:

- reactions to drug chemistry;
- acute toxic effects;
- withdrawal symptoms;
- HIV infection;
- other blood borne viral infections (hepatitis);
- infections at the needle site;
- suicide attempts and completion;
- injuries (road accidents);

- mental health disorders (e.g. depression)
- nutritional problems and deficits;
- eating disorders.

An Australian study (English and D'Arcy cited in Spooner et al., 1996) found that 18.3% of all deaths in Australia (1992) among youth (15 - 19) were substance abuse related. Alcohol abuse was related to both road accidents and suicide. People who are heavily involved in substance abuse during adolescence have five times the mortality rate during early adulthood in comparison with those who are not. However, many of the additional health effects of substance abuse occur after years of regular use.

Key experts identified the following approaches to addressing youth health issues while in treatment. These include:

- A comprehensive physical health assessment (involving a range of health care providers) at treatment entry;

  > *We use a broad screening tool that identifies eating disorders and (other) mental health issues.*
  >
  > ***
  >
  > *There's a medical assessment prior to starting treatment – many of them are on medication – they are taken to appointments (i.e. nutritionist, physician, allergist, psychologist).*

- A holistic interpretation of health and health assessment (including physical, psychological and nutritional components);
- A specific educational program component that provides comprehensive nutritional information;
- Easy accessibility to a range of specialists by clients and staff (e.g. eating disorder specialists, nutritionists);
- A cognitive-behavioural approach to treatment which helps youth explore, identify and practice elements of a healthy lifestyle. Programs need to make available a wide variety of information so that youth can access and use what they need;

  > *Health issues usually have been approached by an educational/behavioural approaches, that makes sense for a healthy lifestyle. For example, protected sex, maintain health, eat, sleep and exercise.*

- The availability of one-to-one counselling to explore health issues in depth;
- Staff who model healthy lifestyle choices;
- A proactive approach to health resources. Some respondents stressed that they like to accompany youth on visits to doctors or clinics in order to provide liaison and support.

12.1.2 Treatment Approaches and Methods to Address Personal Issues (including mental health disorders)

There is a strong association between substance use and mental health disorders. Key experts were asked to identify treatment approaches and methods which effectively address issues related to mental health. In most cases, recommendations for best practices were directed toward youth with less serious disorders (lack of confidence, poor self-esteem).

Although there was a range of responses to this question, there was consensus on only one approach – that the optimal method of addressing personal issues is a skill-building approach which supports the development of positive identity and enhanced self-esteem. Key experts defined skill building as being:

- Comprised of a number of elements, including:
  - building of self-esteem;
  - exploring the meaning of and building a healthy lifestyle;
  - learning tools for anger and stress management;
  - assertiveness skills.
- Taught in a variety of venues and settings using mini-workshops, creative exercises, art therapy, psycho-drama, individual counselling, group work and family therapy;
- Culturally appropriate (in the case of Aboriginal communities comprising teachings about traditional skills and practices and incorporating traditional ceremonies);
- Practical and solution-focussed;
- Fun, creative, experiential (including arts, crafts, games and other recreational opportunities).

12.1.3 Approaches and Methods to Address Interpersonal Issues

There appears to be a strong association between substance use problems and problematic family relationships.

In a study of 1,483 youth (ages 12-19) who had attended treatment programs in the United States, 73% said that they used substances to handle or escape family problems, 54% to "belong with friends" (Bergmann, 1995:455). A significant proportion of these youth came from families described as dysfunctional; 24% reported physical abuse and 38% parental (father) substance abuse.

Key experts stressed the importance of incorporating families in treatment through a variety of means, including family support, family therapy and parent education. The recommended structures for involving families varied. They included:

- 8-week (weekly) parent education groups;
- weekly support groups;
- intensive seminars or workshops;
- direct family counselling;
- involvement in family healing circles.

The importance of involving elders and the family was stressed for Aboriginal youth. A smaller group of respondents identified the importance of using peer groups and interactions to support exploration of interpersonal issues (See Section 15.2).

> *We promote learning from peers and use peer groups for modelling and practicing skills.*

12.2 Best Practices to Address Relapse Management and Prevention

Relapse prevention and management is seen by key experts as an integral part of treatment. Six elements of best practices supporting relapse management or prevention were identified:

- A philosophical approach which perceives relapse not as a failure but as likely to occur and an opportunity for client growth and change;

> *Downplay relapse – don't make it look like a loss, it is part of cleaning up. Abstinence may not be the only route they're going. If they want to go completely clean, go through what happened when they can learn from it.*

- The development (with the client) of a treatment plan and a set of personal goals, small, short-term achievable goals which are visible to the client and which support feelings of success;
- A focus on identifying triggers to substance use and on teaching specific and concrete skills to handle use at critical times (i.e. what are high-risk situations, triggers, avoidance strategies, environmental supports and plans to handle risk situations);
- The exploration of other issues related to relapse (e.g. handling of stress);
- The development of a system of post-treatment aftercare and program contact. Contact may be required for up to one year or longer in some cases;
- The development of connections for youth in the community (counselling support, recreational and other resources) which can serve as supports and skill-building opportunities after treatment has ended.

Table 9: Specific Treatment Approaches and Methods to Support Effective Treatment: Key Expert Perspectives

Areas of Best Practice	Key Expert Themes
Physical health issues	▪ Comprehensive health assessment at treatment entry ▪ Health assessment to include physical, psychological and nutritional status ▪ Nutritional education provided by program ▪ Easy access to specialists (e.g. eating disorders) ▪ Cognitive-behavioural approach to help define health and lifestyle goals ▪ One-to-one counselling to explore health issues ▪ Staff model healthy lifestyles ▪ Staff assist client to access health resources
Personal (mental) health, self-esteem, developmental issues	▪ Skill-building approach which: → Is eclectic → Teaches healthy lifestyles, anger management, stress reduction → Is practical and solution-focussed → Is fun and creative → Is culturally appropriate and presented with variety of venues (group/individual counselling)
Interpersonal issues	▪ Proactive approach to involving families in treatment in a variety of ways ▪ Support for peer group interaction (learning, modelling, support)
Relapse prevention	▪ Philosophical acceptance of relapse ▪ Short-term achievable goals are determined *with* youth ▪ Treatment explores triggers to relapse and responses ▪ Treatment explores other issues related to relapse (e.g., stress) and ways to address them ▪ Program provides long-term aftercare ▪ Development of connections for youth in community to act as ongoing support

12.3 Treatment Approaches: Literature Review

A focussed review of the treatment literature broadly supports the opinions of key experts, although there is an acknowledgment that "research into treatment methods needs to be increased considerably before the efficiency of one procedure over another can be identified and given recognition" (Spooner et al., 1996:6 - 14).

Catalano et al. (1990 - 1991) noted that youth post-treatment relapse rates are high (35% to 85%) and the process of relapse is variable.

> Lapses may be infrequent single uses or infrequent episodes of heavy use for several days. Neither invariably lead to uncontrolled, compulsive use. Some suggest that these lapses may even constitute positive learning experiences (Brownell et al., and Marlatt and Gorden cited in Catalano et al., 1991:1105).

Catalano et al. (1990 - 1991) review of treatment outcome research associated the following elements with treatment success:

- the availability of special services which support the development of client skills (education, training, relaxation, sexual education and recreation);
- the availability of active recreational activities and skill-based recreational opportunities;
- participation of parents or a parental figure in treatment (if parents can contribute constructively);
- availability of family therapy, behavioural family therapy and combined structural/behavioural approaches.

Bergmann et al.'s (1995) post-treatment study of 1,483 youth in more than 30 in-patient and residential treatment programs in North America found that youth with the poorest outcomes at six months post-treatment had the fewest relapse coping strategies and skills.

Emrich (as cited in Bergmann et al. 1995) found that continued therapy and aftercare following completion of in-patient treatment have been predictive of successful treatment outcome. Family support in the recovery process was also strongly associated with post-treatment success. However, Bergmann et al. (1995) noted that family involvement in treatment must be individualized to meet client needs:

> Family participation, in general, is a very important predictor of positive outcome. A structured "one-size-fits-all" family program, however, will never realize its potential effect on treatment outcome. Among certain subgroups of males, the primary family issues on which to focus should revolve around parental substance use, issues of abuse, and establishing behavioural parameters while living at home to facilitate recovery. For females, the family program may be most effective if it is centred around issues of self-esteem, anxiety and providing a supportive environment for recovery. (Bergmann et al., 1995:469)

In a meta-analysis and literature review, Stanton and Shadish (as cited in Weinberg et al., 1998) supported the superiority of family therapy (as opposed to family psychoeducation or support groups) for youth in treatment. Joanning et al. (1992) noted the effectiveness of structural-strategic family therapy (SSFT) which involves all family members, whether or not they are involved in treatment. Other integrated models (multi-dimensional family therapy) have also demonstrated treatment success. Azrin et al., (1994), in a controlled group study, found that cognitive-behavioural approaches (including therapist modelling, rehearsal, self-recording and written therapy assignments, stimulus and urge control and social control/contracting) were associated with post-treatment success.

Although Spooner et al. (1996) acknowledged a lack of research defining effective treatments, on the basis of a review of 17 studies, they concluded that:

> Treatment strategies tend to favour family therapy, skills training and cognitive-behavioural therapy, all of which appear to have some effect on treatment outcome. With family therapy, however, not all adolescents have sufficient support from their families to facilitate treatment outcome, thus diminishing the value of this form of treatment for some adolescents. (Spooner et al., 1996:6 - 14)

13. Program Structure, Duration and Intensity

13.1 Program Structure and Duration: Key Expert Perspectives

13.1.1 Program Structure

There was strong consensus among key experts that youth treatment should be separated from adult treatment. Reasons for a clear separation include:

- the need for youth treatment to focus on developmental issues not of interest to adults;
- the inability of youth to explore "childhood issues" which are significant to adults;

- differences in adult/youth treatment motivation;
- differing adult/youth perspectives on life and needs;
- the risk of youth being exploited in adult treatment settings.

A second element of best practice defined by key experts was the importance of client "matching" to treatment. Treatment options need to be flexible and based on an assessment of youth needs and motivation. Key experts also identified the need for a *continuum* of services which would include:

- detoxification services;
- street outreach;
- prevention;
- residential;
- out-patient day treatment;
- continuing care.

The continuum of services was described as starting with the least intrusive and moving to the most intrusive level of services.

Most respondents described all modes of treatment as valid and concluded that the specific form of treatment should be determined by individual needs. A small group of respondents identified out-patient treatment as the most effective form of treatment for most youth because it enables clients to practice life skills and coping strategies in realistic settings. Youth most likely to require residential treatment include those who:

- are using solvents;
- come from families where parents are misusing substances or where there is a high level of neglect;
- have unresolved grief due to historical abuse issues;
- have had limited treatment success in the past due to the presence of other issues which could be minimized in a residential setting.

13.1.2 Program Duration

A range of recommendations was made related to the optional duration of treatment. Key experts stressed there is no "cookie cutter" approach to treatment length and that treatment length depends on clients' needs, their developmental stage and "stage of change." There was general consensus that duration of out-patient treatment should be in the range of three to six months *not* including some structured form of continuing care.

There's a different duration for different needs – some kids need months, years in day treatment, others need two to three months residential and some long-term up to six months, some kids need at least 30 days plus ongoing aftercare.

***

We have a rotating, modular program i.e. one month's Native healing, one month in life skills, one month specific (harm) reduction strategies so that youth can come into the program at any time.

Key experts noted that specific groups (e.g. youth who use solvents) may require up to two years in treatment.

Table 10: Program Structure, Duration and Intensity: Key Expert Perspectives

Areas of Best Practice	Key Expert Themes
Program structure	▪ Youth treatment separate from adult treatment ▪ Client matching determines treatment type ▪ Continuum of services necessary ▪ Least intrusive type first ▪ Out-patient and residential both useful for different clients ▪ Out-patient most useful for skill practice ▪ Residential best for clients with more severe disorders or issues (e.g. unsupportive families, solvent abuse).
Program duration	▪ No standardized approach; based on client needs, stage of change ▪ 3 - 6 months minimum for out-patient ▪ Others (e.g., solvent abusers) 1 - 2 years ▪ Continuing critical (up to 1 year).

13.2 Treatment Structure, Duration and Intensity: Literature Review

The impact of treatment structure (residential, non-residential and day programs) on treatment outcome has been controversial in the literature. In a review of nine major studies examining the impact of residential versus sessional treatment, Spooner et al. (1996) found that there is no evidence to suggest that residential treatment is more effective than sessional intervention in the treatment of alcohol dependence. The authors concluded that:

> The argument that residential treatment must be retained as the mainstay of intervention for substance dependence for adolescents or adults is unconvincing. However, there is a good case to be made for the use of residential facilities for the client who is homeless, or for whom the usual environment is so conducive to substance use that a form of residential care is appropriate. (Spooner et al. 1996:6 - 9)

In a review of several adult treatment studies, Catalano et al., (1990-1991) found that duration in treatment was more strongly related to treatment success for residential clients than for out-patient clients. Feigelman et al. (1988) found that youth who had stayed longer in treatment (1 year as opposed to 6 months) used fewer substances after treatment and had fewer associated problems. However, time in treatment was less important than other program variables (e.g., staff characteristics).

14. Support Services: Type and Integration

14.1 Required Support Services: Key Expert Perspectives

There was general consensus among key experts that successful youth treatment is holistic, eclectic and comprises of a range of associated services. Key experts were asked to identify the most critical adjunctive services:

- specialized mental health services and connections with clinical therapists and child psychiatrists;
- health services (to address general physical health issues);
- education services (full range of educational services and support from school support to home study or tutoring);
- housing support services to provide safe and secure housing for street-involved youth;
- recreational services to support skill building;
- services directly applicable to First Nations and Inuit youth to teach and address language issues, and to facilitate culturally supportive practices and linkages (e.g. spiritual and traditional practices);
- employment and apprenticeship training.

14.2 Optimal Integration of Services: Key Expert Perspectives

Key experts identified several ways of integrating these critical support services. The most frequently recommended option for integrating services is a case management model bringing major players together using a coordinated approach centred on individual youth needs.

We need multidisciplinary teams (the people in the youth's life) – teachers, probation officers – must meet together with youth to address problems and look for solutions.

***

Have one person – a primary person organize the key players.

Other recommendations for the integration of services were:

- the development of comprehensive services by the agency providing treatment;
- the use of existing systems (e.g. school) as "gateways" to accessing other resources (e.g. recreational services);
- integration of specific services and resources into the program (e.g. school and recreational services). These services could be managed by other agencies but would be under the umbrella of the treatment program.

Specific literature describing best practices related to the identification and integration of adjunctive services for youth treatment was not available.

15. Additional Best Practices: Key Expert Perspectives

15.1 Staff Characteristics

Key experts were asked to identify other elements of treatment associated with positive treatment outcomes not discussed in the broad areas described above. A range of best practices was described, many replicating previous themes (e.g. harm reduction, client/treatment matching). A significant new theme that emerged was the importance of *specific staff charcteristics* as a factor related to treatment outcome and success. Staff qualities were described in relation to attitude, background and skills. In terms of attitude, key experts described the most effective therapists as being able to:

- show respect and trust;
- minimize the hierarchical power structure and work collaboratively with youth;

  Workers have to be respectful. They have to choose and want to work with youth, and like them. All the rest is teachable but that isn't. As adults, we need to know how to be comfortable with being challenged by them; we can't get into power struggles.

- build and maintain a positive rapport with clients over the long term (including after program termination);
- accept relapse and not define it as a failure;

- help youth redefine themselves in new, more positive ways;
- model a positive, healthy lifestyle.

The most important aspect of staff background defined by respondents was the ability to speak with familiarity (and experience) to issues of importance to youth. Direct familiarity with different cultures and issues related to sexual orientation were emphasized. In terms of specific staff skills, respondents stressed the need for staff to:

- be trained and qualified;
- understand youth developmental issues and changes;
- understand conceptual tools such as the "Stages of Change" model and motivational interviewing.

15.2 Involvement of Healthy Adults/Group Therapy

Key experts highlighted two aspects of treatment:

- the importance of involving other healthy, consistent adults in youth treatment (in addition to family);
- the value of group therapy as an important method of treatment.

Key experts favoured group therapy over one-to-one therapy. Supporting positive peer connections through group work was considered to be a very valuable component of clinical practice. However, it was also stressed that not all youth do well in groups.

15.3 Wider Scope of Treatment Availability

Key experts also noted that there was a lack of certain types of treatment resources and options for youth, making success difficult to achieve. Specific gaps were noted in the following areas:

- a lack of residential treatment, especially regionally based resources;
- specific treatment for youth with fetal alcohol syndrome/fetal alcohol effects (FAS/FAE);
- easy and timely access to treatment;
- treatment for gay and lesbian youth;
- gender-specific treatment.

Table 11: Best Practices: Additional Elements: Key Expert Perspectives

Areas of Best Practice	Key Expert Themes
Staff characteristics	Attitude: ▪ Respectful, shows trust ▪ Minimizes power structure ▪ Builds positive rapport during and post-programs ▪ Helps youths redefine new positive self ▪ Models healthy lifestyle Skills: ▪ Trained/qualified ▪ Understands youth and developmental issues Background: ▪ Awareness with issues important to youth (e.g. cultural issues, sexual orientation)
Additional issues	▪ Non-family adult role models required in youth's life ▪ Value of group therapy ▪ Need to address gaps in services – residential – FAS/FAE – increased accessibility – treatment for gay and lesbian youth – gender-specific treatment

15.4 Additional Best Practices: Literature Review

15.4.1 Staff Characteristics

The quality of the staff/client relationship has been identified in the literature as an important determinant of treatment success. In a review of several studies, Russell (1990) described specific staff characteristics which are likely to be related to successful youth treatment programs, and concluded that effective staff are:

- engaged with clients;
- relaxed and caring;
- able to be spontaneous;
- objective;
- likeable;

- able to "get down to the level" of adolescents;
- past their own adolescent issues but able to recall and be sensitive to them;
- able to project confidence.

Alexander et al. (in a study cited by Russell, 1990) indicated that it is the global quality of the staff relationship with clients that accounts for most outcome variance. Alexander et al. (as cited in Russell, 1990) concluded that relationship skills combined with a well-structured agenda and operational program framework are both essential to treatment success. Spooner et al. (1996) also attempted to define staff characteristics associated with optimal outcomes. Characteristics summarized from several studies include:

- a sense of humour;
- ability to be encouraging and reinforce positive behaviour;
- a *lack* of confrontation and directedness;
- the ability to develop a warm and supportive relationship with clients.

Luborsky (as cited in Spooner et al. 1996) found that the ability of a therapist to form a warm, supportive, therapist/client relationship, and a "helping-alliance" early in treatment was significantly correlated with the outcome. He also found that consistency in applying established treatment procedures was also correlated with treatment success.

A comparative study (McLellan et al. as cited in Spooner, 1996) of four different "types" of treatment providers found that the most effective were better organized, saw clients frequently, kept better case notes, were more consistent in their application of program policies and referred to specialists frequently. The *most* effective counsellors anticipated problems in each client's life and developed strategies in collaboration with clients to help resolve these problems.

In a study by Friedman and Glickman (as cited in Catalano et al. 1990 - 1991), 65 program variables were correlated with treatment outcomes. Staff-related variables showing significant correlation with treatment success were:

- number of years counsellors had worked in the counselling field;
- number of volunteer staff in direct contact with clients;
- degree of counsellor's use of practical problem-solving approach with client.

16. Measuring Treatment Outcomes

16.1 Measuring Treatment Outcomes: Key Expert Perspectives

The focus of this report has been to identify best practices associated with treatment success. Key experts were asked to define "successful treatment" by specifying outcome indicators which demonstrate success. Although reduction in substance use continues to be a major indicator of success from the point of view of many key experts, most see success in a more complex and multi-dimensional way. Other variables to measure success, identified by key experts, include:

- Improvements in the client's quality of life in general (e.g. health status);
- A more positive self-assessment (by client);
- The achievement of client-established outcomes/ability to meet a range of self-determined goals in a variety of life areas;

> *Success varies, may be learning how to pay rent.*
>
> ***
>
> *Each success means a factor of stability – increases prognosis of coming out unharmed.*

- Improvements in knowledge about substance impacts;
- Decreased involvement of client with police or justice system;
- Increased retention in school and ability to function well in school;
- Client satisfaction with treatment program;
- Treatment attendance and completion;
- Improvement in general life coping—ability to function in many life areas (peer relationships, school attendance, housing);
- Ability to reduce harm from substances and to protect self;
- Improved family relationships.

Key experts are in general agreement that outcome indicators are not uniform, and must be client defined. There was no agreement on the comparative weighting of these variables.

17. Model Program Elements

The following table summarizes the program elements described by key experts as being most likely to achieve positive outcomes for clients in treatment. Details on these elements are provided in the text.

Table 12: Model Program Elements: Key Expert Summary

Component of Treatment	Accessibility	Program Approach and Philosophy	Assessment/ Intake	Methods	General Outreach	Staff/Client Relations	Family Involvement
Underlying Principles (All Components)		Program: ■ Is highly individualized and client-centred ■ Supports harm reduction model ■ Supports menu of approaches and methods ■ Treats youth within system of relationships ■ Provides safe and respectful treatment ■ Involves families ■ Treatment includes physical, emotional and spiritual elements ■ Provides least intrusive treatment initially ■ Staff respect basic worth of youth ■ Learning is experiential ■ Is based on positives not deficits ■ Is based on skill building which enhances self-esteem					
Client Engagement Phase	■ Staff visible at all youth locations ■ Immediate 24-hour access ■ Low threshold of admission criteria ■ Program has drop-in component	■ Program develops prevention activities as "gateway" to program services ■ Program services offered in a safe, secure and comfortable environment ■ Program is client-centred		■ Program offers non-threatening recreational activities ■ Uses connections with community and school-based prevention activities	■ Support/training to school and other key professionals ■ Extensive, well-maintained referral networks	■ Program staff prepared for long-term relationship ■ Staff respectful, non-judgmental ■ Staff understand youth reality	Early involvement of family members
Client Retention		■ Program uses harm reduction model ■ Program is flexible	■ Program does client/treatment matching	■ Program uses psycho-educational approach ■ Provides culturally appropriate activities ■ Provides recreational activities ■ Is fun for clients	■ Program provides concrete information about services which is honest, creative and is provided prior to intake	■ Staff are respectful and supportive	■ Program involves families ■ Addresses family needs using a variety of approaches

Table 12: Model Program Elements: Key Expert Summary (cont'd)

Component of Treatment	Accessibility	Program Approach and Philosophy	Assessment/ Intake	Methods	General Outreach	Staff/Client Relations	Family Involvement
Specific Treatment Approaches and Methods		Cognitive behavioural approach helps youth determine and try out healthy lifestyle choices. ▪ Skill-building approaches enhance self-esteem ▪ Program espouses philosophical acceptance of relapse	Comprehensive and multi-dimensional health assessment is provided at intake	▪ Nutritional information is provided ▪ Group therapy is preferred option ▪ One-to-one counselling optimal for exploring personal health issues ▪ Skill building teaches stress reduction, life skills, anger management ▪ Skills taught in variety of ways (group, individual counselling, creative methods) ▪ Skill building provides cultural skills information ▪ Triggers to relapse explored ▪ Staff use "Stages of Change" model and motivational interviewing ▪ Relapse prevention built into treatment plan	▪ Program facilitates access to specialists ▪ Staff connects clients to health-oriented recreational and other resources ▪ Clients actively helped to access resources ▪ Development of connections to ongoing recreational community activities ▪ Staff prepared for long-term relationship ▪ Staff accept relapse ▪ Staff have experience with cultural background of clients ▪ Staff are trained and qualified ▪ Staff understand youth developmental stages	▪ Staff model healthy lifestyle choices ▪ Staff show respect and trust ▪ Staff minimize unequal power relationship	▪ Families involved through therapy, support or education ▪ A variety of support and education formats are offered

Table 12: Model Program Elements: Key Expert Summary (cont'd)

Component of Treatment	Accessibility	Program Approach and Philosophy	Assessment/ Intake	Methods	General Outreach	Staff/Client Relations	Family Involvement
Structure and Duration of Program		■ Treatment is youth specific ■ Continuum of services available ■ Out-patient treatment preferable for skill testing ■ Residential treatment appropriate for high need ■ No clear duration defined ■ 3 - 6 months may be necessary in out-patient ■ Continuing care critical		■ Considers client needs, developmental stage and stage of change	Different models: ■ Services integrated through case coordination ■ Services accessed directly through community ■ Program provides all services		
Support Services Integrated During Treatment					The following adjunctive services are integrated into the client's life: ■ Mental health services ■ Range of (physical) health services ■ Educational/ school services ■ Housing ■ Recreational services ■ Aboriginal spiritual, traditional services ■ Employment apprenticeship training		
Continuing Care				■ Specific continuing care is arranged ■ Continuing care may be required for up to 1 year ■ Clients encouraged to see relapse as learning opportunity ■ Clients use relapse prevention skills	■ Clients connected to ongoing community services	■ Post treatment relationship continues	

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